

## North Carolina Money Follows the Person Informed Consent Form

Name:	Social Security Number:
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MFP is an important demonstration project that will assist NC individuals move from institutions back into the community.

You should know that:

Eligibility requirements for MFP are: reside in an institution or nursing facility for a minimum of 6 months prior transition; Medicaid eligible one month prior to transition; Move into a qualified community residence:

- A home owned or leased by the individual or the individual's family member
- An apartment with an individual lease, with lockable access and egress, and that includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control
- A residence in a community-based setting in which no more than four unrelated individuals reside

Participation includes meeting the eligibility requirements /criteria for Community Alternatives Program (CAP) waiver services or PACE.

As a participant in this project, I am enrolling in a CAP waiver or PACE on the first day out of the facility/institution.

Participation in MFP is voluntary.

Participant receives demonstration services for a total of 365 days.

You can withdraw from participation in the MFP project at any time. Your case manager will have a withdrawal form for you to fill out and sign.

Participate in developing an independent living plan/plan of care with which includes goals and persons responsible for reaching the set goals. I will work in partnership with the organization to achieve my goals in the manner and time agreed upon by the staff person and me.

Participation includes acceptance of demonstration services

Supplemental supports for community living such as one-time transition expenses to enable success upon entry into the community.

You will participate in three surveys about your quality of life while living in the community

Any information collected about you will be confidential and only be used for evaluating the project

Live in the community of your choice as opposed to an institution or nursing home.

Upon conclusion of 365 days in MFP project, you may continue with CAP waiver services so long as the level of care assessment conducted annually indicates a continued need.

If re-institutionalized for more than 30 consecutive days, you will be reevaluated for continued MFP eligibility and have an updated Plan of Care. If after three incidences/occurrences of re-institutionalization of 30 consecutive days or longer, you will no longer be considered for reentry into the Money Follows the Person project.

If you do not join the project, you can still receive Medicaid 1915(c) waiver services as long as you meet the eligibility requirements.

You will be provided information about MFP. You will be provided an opportunity to review this information and have your questions answered.

Right to appeal as per the CAP Waiver or PACE in which enrolled.

**Complaints:**

Contact: The Department of Health and Human Services Ombudsman Program was created to address inquiries and complaints that consumers and their legal/guardians have regarding services that Department of Health and Human Services oversees or administers. The Regional Long Term Care Ombudsmen program can also be accessed through the CARE-LINE and is available 24 hours a day/7 days a week, by calling 1-800-662-7030 (English/Spanish) or 1-877-452-2514 (TTY).

**Consent:**

My signature below indicates the following:

I have received information about MFP;

My questions about the MFP project have all been answered to my satisfaction;

I acknowledge my understanding of the MFP project; and

I accept to participate in the MFP project, if I am determined eligible;

<b>MFP Participant Acknowledgement</b>	
Participant Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone No.:	
<b>Guardian/Legal representative Acknowledgement (if applicable)</b>	
Guardian/Legal Representative Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone No.:	
<b>Case Manager Acknowledgement</b>	
I have read and explained this document to the applicant. I believe that he/she (or the guardian/legal representative, if signed) understood this document.	
Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone No.:	
<b>Witness Signature, if applicable (if X'd)</b>	
Signature:	
Date Signed:	
Mailing Address:	
City, State, ZIP	
Telephone No.:	